STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445156	A. BUILDING _____ B. WING _____	C 10/27/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL MANOR HEALTH CARE	902 BUCHANAN RD NEW TAZEWELL, TN 37825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility investigation documentation, review of facility policy, observation, and interview, the facility failed to implement the abuse policy for one resident (#5) of six sampled residents. The findings included: Resident #5 was admitted to the facility on September 6, 2005, with diagnoses including Alzheimer's Disease. Medical record review of a Minimum Data Set dated June 2, 2010, revealed the resident was severely impaired with decision-making and communication skills, free of mood/behavioral problems, and required assistance of staff with hygiene. Medical record review of a nurse's note dated July 21, 2010 at 10:00 p.m. revealed, "Called to resident room...Upon assessment of patient large amount of dark purple and black bruising noted on inner bilat (bilateral) thighs and pubic area...old greenish bruising noted on bilat thigh Resident unable to explain origin..." Medical record review of a nurse's note dated July 22, 2010 at 12:35 a.m. revealed, "Transport to...ER (emergency room)..." Medical record review of an emergency room		**F226 D** Resident #5 was assessed by her attending physician at 11:35 pm on 7-21-2010 in the facility. Aspirin medication regime was ordered to be held X 3 days. Resident was monitored closely for 72 hours for adverse affects. No adverse affects noted. One to one education training, by the Director of Nursing, was conducted with the one licensed staff member that failed to document and report timely. The facility will implement policy that prohibits mistreatment, neglect, abuse, and misappropriation of resident property for resident #5. The facility will implement and follow the abuse prohibition policy that includes timely investigation, timely reporting, and timely documentation for all residents. One to one education training, by the Director of Nursing, was conducted with the one licensed staff member that failed to document and report timely. Inservice education will be conducted by the Director of Nursing to re-educate all staff by November 19, 2010, the education sessions will cover a comprehensive review of the facility abuse prohibition policy which includes timely reporting, timely investigation, and timely documentation. The facility CQI Committee comprised of the Medical Director, Administrator, Director of Nursing, Social Worker, and Unit Managers will review resident care management processes monthly to check for compliance of the abuse prohibition policy.	11-19-2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Juanita Bruzzell — TITLE: Administrator — (X6) DATE: 11/5/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 226	Continued From page 1 provider record (included in the facility's medical record for #5) dated July 22, 2010 revealed, "...Chief complaint: ...bruising of L (left) thigh...large bruise...groin area; no known injury...ecchymosis (bruising) noted over L (left) groin and hip extends medially nearly to knee..." Medical record review of an emergency room nursing record dated July 22, 2010 revealed, "...very significant bruising on inside of thighs bilaterally...(police department) notified of mult (multiple) bruising...poss. (possible) abusive actions..." Medical record review of a nurse's note dated July 22, 2010 at 3:10 a.m. revealed the resident returned to the facility. Review of facility investigation documentation dated July 21, 2010 revealed, "...10:00 p.m...called to resident room...large amount bruising on inner thigh and pubic area...taken to...County Hosp. (hospital) witnessed by (licensed practical nurse - LPN) #1..." Review of facility investigation documentation dated July 21, 2010 revealed, "I was working...on 7-2-10 when I noticed bruising on...bottom and...legs I ask (asked)...what happened...said it had been reported to the nurse over the weekend." Review of facility documentation dated July 21, 2010 revealed, "Called to...room on 7/20/10 where I observed bruising to (L) leg all the way to anal area with bruising to...(right) upper leg...proceed to notified (LPN #1)." Review of facility investigation documentation dated July 21, 2010 revealed, "I was told about the bruising tonight 7-21-10. From I saw...had bruising thigh left side and right Also in pubic area. On...left leg, it looks like a bruise from an arm pushing."	F 226		

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F 226	Continued From page 2 Review of facility policy revealed, "Resident Abuse...procedure for reporting suspected mental and/or physical abuse...will complete an incident report and began an investigation immediately, documenting their findings because key evidence may be lost in first few hours...Supervisor will follow incident reporting procedures..." Observation on October 21, 2010 at 11:50 a.m. revealed the resident seated in a wheelchair in the room, unable to communicate, and free of visible bruises. Interview with the administrator on October 22, 2010 at 2:00 p.m. in a conference room revealed the facility had not investigated the resident's injuries as possible abuse or reported an allegation of potential abuse as required. Continued interview confirmed the facility had failed to implement the abuse policy for sampled resident #5. C/O: #26845	F 226		